J-1 VISA PHYSICIAN EMPLOYMENT VERIFICATION FORM INSTRUCTIONS

PURPOSE

The purpose of this form is to verify the employment status of J-1 VISA Physicians placed by the Primary Care Office. The physicians are required to work at least three years at the sponsoring medical facility approved practice site.

INSTRUCTIONS

J-1 VISA Physicians placed by the Primary Care Office (PCO) and a representative of the medical facility sponsoring the J-1 VISA Physician should complete and submit the form to the Primary Care Office every six months. The PCO will mail the form every six months to the active J-1 Physicians in the office database.

The following should be provided on the form:

Section I
Place check in type of J-1 VISA Program.

J-1 VISA Physician should provide contact information in Section I. Information includes physician name, complete home address, and home telephone number.

The J-1 VISA Physician should also provide approval date from INS (Immigration XXX Services) or H-1 B VISA approval date.

Section II
J-1 VISA Physician should provide the following for the sponsoring medical facility practice site: facility name, complete address, telephone number, fax number, county location, and HPSA information.

Section III
J-1 VISA Physician needs to certify working 40 hours per work providing health services at medical facility listed in Section II **(must be notarized)**

Section IV
Representative of sponsoring medical facility must certify that J-1 VISA Physician is working 40 hours per week providing health services at medical facility practice site listed in Section II **(must be notarized).**

OFFICE MECHANICS AND FILING

This form is sent every six months to active J-1 Physicians in the Primary Care Office (PCO) database. The form is completed by the J-1 Physician and a representative of the sponsoring medical facility of the J-1 Physician and must be notarized. The form is returned to the PCO and is placed in the J-1 Physician's file.

RETENTION PERIOD

The J-1 Physician file is kept in the PCO for seven years.

J-1 VISA PHYSICIAN VERIFICATION OF EMPLOYMENT FORM

SECTION I

Conrad State 30 ☐ ARC ☐

PHYSICIAN NAME: _____
Please Print

EMPLOYMENT START DATE:

INS J-1 Visa Waiver Approval Date: _____ H-1(b) Visa Approval Date: _____

HOME ADDRESS:
Street: _____

City: _____ State _____ Zip Code:

Home Phone: (_____) _____

SECTION II

Type of Medical Practice

Name and Location of Medical Practice

_____

_____ _____
Street City State Zip Code County

_____
HPSA (include specific County, C.T., CCD, BORO, etc.)

Phone: _____ FAX: _____

SECTION III

I HEREBY CERTIFY THAT I, THE UNDERSIGNED, DO PROVIDE PRIMARY HEALTH CARE SERVICES AT THE ABOVE STATED LOCATION(S) A MINIMUM OF 40 HOURS PER WEEK.

_____ _____
Physician's Signature Date
(Notary)

SECTION IV

EMPLOYER/SPONSOR:

I HEREBY CERTIFY THAT DOCTOR _____ BEGAN

PRACTICING AT _____ ON
AND PROVIDES A MINIMUM OF 40 HOURS PER WEEK OF PRIMARY HEALTH CARE IN THE ABOVE LISTED HPSA LOCATION(S).

_____
Name of Employer/Sponsor Representative (Please Print)

_____ _____
Employer/Sponsor's Representative Signature Date
(Notary)

RETURN THIS FORM BY MAIL TO THE FOLLOWING:

MISSISSIPPI STATE DEPARTMENT OF HEALTH
OFFICE OF RURAL HEALTH & PRIMARY CARE
570 EAST WOODROW WILSON - P. O. BOX 1700
JACKSON, MISSISSIPPI 39215-1700
TELEPHONE #: 601-576-7216